

An Exploration of Common Elements in Dialectical Behavior Therapy, Mentalization Based Treatment and Transference Focused Psychotherapy in the Treatment of Borderline Personality Disorder

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Abstract A number of leading practice models have been found to be effective in the treatment of Borderline Personality Disorder (BPD). These include Dialectical Behavior Therapy, Transference Focused Psychotherapy and Mentalization Based Treatment. This article reviews the current evidence for these dominant practice models, and concludes that no single treatment has been found to be consistently superior in the treatment of BPD. Given the lack of evidence privileging one single model of treatment, and the fact that it is not always feasible or desirable for social workers to practice using pure manualized treatment models, there is a need to develop more integrative approaches to treatment with this vulnerable population. By highlighting specific similarities and differences between practice techniques, this paper attempts to pave the way toward developing a more integrative treatment approach to working with individuals with BPD, an approach where interventions are selected based on appraisal of the evidence, clinical expertise, and client need.

Keywords Dialectical behavior therapy · Transference focused psychotherapy · Mentalization based treatment · Borderline personality disorder · Integration · Common elements

Introduction

While social workers have historically been committed to meeting the unique and varied needs of clients, the theories we draw upon in our work are often developed and discussed in ways that suggest that each model should be used in isolation. Practice models frequently have an underlying assumption that a single model is able to meet the myriad needs of each client. Yet, there is little evidence that any one model is able to sufficiently address the complex difficulties faced by the clients we serve or is consistently superior to another in terms of outcomes (Wampold et al. 1997). In practice, social workers report drawing from numerous models in their work. In a survey of clinical social workers, Pignotti and Thyer (2012) found that 42 % of respondents reported using cognitive-behavioral therapy, 21 % reported using psychodynamic therapy, and 17 % reported using solution focused therapy. 31 % of respondents reported being eclectic or using combinations of theoretical orientations. Despite the frequency of practitioners drawing from diverse practice models, there is little in the literature that describes how clinical social workers should integrate different models of treatment and interventions while working with one individual. Notable exceptions to this include Heller and Northcut (1996) and Goldstein (1999) in their discussions of the treatment of individuals with Borderline Personality Disorder using CBT and psychodynamic treatment models.

Far more commonly, the literature defends “pure” models of treatment. For example, Chapman et al. (2011) argue that Dialectical Behavior Therapy should be used in isolation, despite the fact that the evidence supports a variety of practice models in the treatment of Borderline Personality Disorder (Zanarini 2009). The adherence to single practice models limits our ability to think critically about which

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aspects of models are most useful for which clients, and under which conditions. In addition, because clinicians from one practice orientation tend to read only literature within their area of interest, there is little “cross-pollination” of ideas between models. This myopic form of practice leads to many false arguments between clinicians, who may in fact be practicing quite similarly, but using a different nomenclature for similar interventions. These commonalities between models may partially explain why the evidence from psychotherapy research often finds support for a multitude of practice models (Wampold et al. 1997).

It seems time to challenge dogmatic arguments supporting pure models of practice, and instead, to work toward an understanding of similarities and differences between models. In this way we can eventually discover how clinicians can, and do, successfully use the best of multiple models of treatment to meet the needs of each client. Clinical social workers have long been integrating interventions from various models and using “practice wisdom” and client preferences to guide them in their choice of interventions. However, much of the evidence based research uses rigid manualized treatments, which may bear little resemblance to how social workers actually practice (Brekke et al. 2007). There is a growing literature on the need for research on therapeutic models that will translate into “real world” practice (Glasgow 2009) yet there is little in the literature that attempts to bridge the gap between evidence based findings and the actuality of clinical practice.

This may be, in part, because eclecticism has often been frowned upon as a euphemism for practicing without theoretical grounding, or “from the hip,” so many social workers may be hesitant to enter into a conversation about how they integrate different models in their work. Nevertheless, some have discussed the importance of “technical eclecticism,” or the selection of techniques from different schools of therapy that best meet the needs of the client in clinical practice (Arkowitz 1992). An APA Presidential Task Force on Evidence Based Practice (2006) concluded that “research suggests that sensitivity and flexibility in the administration of therapeutic interventions produces better outcomes than rigid application of manuals or principles” (p. 278).

Common Elements and Common Factors

The first step in a more integrative approach may be to identify “common elements” between practice models. Chorpita et al. (2005) have introduced a “common elements approach” which identifies specific common techniques and procedures that make up evidence-based protocols. While recognizing there are unique and perhaps important components of each evidence-based model, they assert that evidence-based treatments share many of their “practice

elements” and that these elements can be distilled down to “common elements” which are then matched to client characteristics and needs. The authors encourage practitioners to incorporate elements of manualized treatments into their treatment plans, using clinical judgment and theory to best meet the needs of individual clients. While similar to the “common factors” model (Drisko 2004; Cameron and Keenan 2010), common factors is a broader term that includes all conditions and processes that positively influence practice outcome across a range of practice theories. These components include client factors, practitioner factors, relationship factors, practice factors, change factors, and social network factors (Cameron and Keenan 2010). While there is some overlap between “practice factors” and “common elements,” common elements are specific interventions drawn from manualized treatments with the expressed purpose of ultimately determining what works for whom, and under what conditions (see Barth et al. (2012) for further discussion of common elements and common factors).

This article contributes to the literature by elucidating the common elements and differences between three dominant models of psychotherapy (Mentalization Based Treatment, Transference Focused Psychotherapy and Dialectical Behavior Therapy) for individuals suffering with Borderline Personality Disorder. By highlighting specific similarities and differences between practice techniques, the paper attempts to lay the groundwork for further discussion on how social workers might choose and integrate the most effective set of *interventions* for each client into their work.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a treatment model that has demonstrated effectiveness in addressing a number of behavioral, cognitive and emotional symptoms experienced by people diagnosed with Borderline Personality Disorder (BPD) (Linehan 1993). DSM-5 defines BPD as a pervasive pattern of instability of interpersonal relationships, self-image, affects, and impulsivity (APA 2013). Linehan (1993) conceptualizes the development of BPD as stemming from interacting biological and environmental factors that contribute to distortions in thinking and difficulty regulating emotions. A predisposition to emotional dysregulation and an invalidating environment are understood to contribute to the etiology of BPD. DBT is a highly structured treatment that incorporates cognitive behavioral theory and techniques with those of the Eastern meditative philosophies, particularly mindfulness meditation. DBT treatment includes the use of several different treatment modalities, including individual therapy, group skills training, telephone coaching, and a consultation team for

therapists. Each modality has its own purpose and is a required part of the overall treatment. DBT emphasizes both acceptance and change in the process of healing. The therapist teaches clients specific skills such as mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance to help them deal with their intense emotions and to limit behavioral dysregulation (Linehan 1993).

Evidence for DBT

As an increasingly popular treatment for clients who are considered “high-risk,” there have been multiple studies over the past several years that evaluated the efficacy and effectiveness of this treatment for a range of symptoms including, suicide attempts (Linehan et al. 2006), suicidal ideation (Koons et al. 2001; Linehan et al. 2006; Linehan et al. 1999), self-injury (Linehan et al. 1999; Stepp et al. 2008; Verheul et al. 2003), depression (Koons et al. 2001), anger expression (Koons et al. 2001), inpatient hospitalizations (Linehan et al. 2006), social adjustment issues (Linehan et al. 1999), identity issues (Stepp et al. 2008), and substance abuse (Linehan et al. 2002; Linehan et al. 1999). In addition, a meta-analysis of sixteen studies was conducted by Kliem et al. (2010) to evaluate the efficacy and long-term effectiveness of DBT as a treatment model for BPD. Overall, they found that DBT is an effective treatment for BPD and that it is useful in clinical practice with clients who have been suicidal and/or have engaged in self-injurious behavior.

DBT has been well-studied with more randomized control trials than any other model. While the literature demonstrates that DBT is effective with a range of symptoms and in a range of settings, many other treatments have also demonstrated effectiveness with suicidal behavior, parasuicidal behavior and other symptoms. Kliem et al. (2010) found DBT to be effective in the treatment of BPD when compared to treatment as usual, but they also found “no evidence for the relative efficacy of DBT compared with other borderline-specific treatments” [*italics added*] (p. 945). The authors of the study note, however, that this finding does not necessarily mean that the treatments for BPD are equivalent. There are indications that different forms of psychotherapy may have different impacts on specific symptoms of BPD, a finding we will explore further.

Transference Focused Psychotherapy

Transference Focused Psychotherapy (TFP) is based on Kernberg’s (1985) object relations model of BPD. Kernberg asserts that the primary difficulty in BPD is that high levels of negative emotion and aggression interfere with the normal developmental process of integrating negative and positive internal representations of self and others (Levy et al. 2006a).

As a result, individuals with BPD tend to experience the world in “black and white” terms, seeing the self and others as “all good” or “all bad.” According to TFP, the primary mechanism for therapeutic change is integrating these disparate self and other representations into a coherent whole. Kernberg asserts that through the exploration and eventual integration of “split off” self/other representations, the client develops the capacity to “think more flexibly, realistically and benevolently” (Levy et al. 2006a, p. 486).

This integration of representations is thought to take place through a structured treatment approach and the use of clarification, confrontation, and transference interpretations. The therapy focuses on the “here and now” affects, enactments, and themes that are played out in the relationship with the therapist. TFP suggests that the ability of the therapist to tolerate, contain, reflect on, and understand these intense affective states within the therapeutic relationship allow the client to begin to integrate positive and negative affective states, and to develop the cognitive capacity to represent the affect, which in turn assists with emotion regulation (Levy et al. 2006a).

Evidence for TFP

Transference Focused Psychotherapy has been shown to be effective in the treatment of individuals with BPD. Clarkin et al. (2007) studied 90 subjects with BPD and randomly assigned them to TFP, DBT, or supportive psychotherapy. The results indicated that all three forms of psychotherapy were associated with significant positive change in depression, anxiety, global functioning, and social adjustment. However, only TFP and DBT were significantly associated with improvement in suicidality. Additionally, TFP was more predictive of change in anger, irritability, and verbal and direct assault than the other forms of therapy. Gissen-Bloo et al. (2006) also found support for TFP in an outpatient setting, but found that the group receiving Schema Focused Therapy, an integrative cognitive therapy, had a higher recovery rate, and a lower drop out rate than TFP. However, TFP has also been found to be the only treatment model to be associated with greater improvement in secure attachment and reflective capacity (Levy et al. 2006a). Finally, Doering et al. (2010) found that TFP was superior to treatment by experienced community psychotherapists in the domains of borderline symptomatology, psychosocial functioning, and personality organization.

Mentalization Based Treatment

Bateman and Fonagy (2010) have developed an alternate form of psychodynamic therapy for individuals with BPD. According to this model, BPD is seen as disorder of

attachment, separation tolerance, and mentalization. Mentalization is the client's ability to think about oneself in relation to others, and to understand another's state of mind. Bateman and Fonagy (2010) also call this reflective capacity or reflective function. When patients are unable to mentalize, they rely on other modes to make sense of their experience. For example, in "psychic equivalence mode," the client assumes that what is in his or her mind, accurately reflects reality. For example, if she *feels* abandoned, she assumes the person involved must *be* purposefully rejecting her. In this mode, the client is unable to consider alternate explanations for the behavior of others.

In Mentalization Based Treatment, the client and therapist collaborate to explore alternative perspectives to the patient's subjective experience of self and other. This manualized treatment includes validating and supportive interventions, as well as interventions which use the therapeutic relationship as a conduit through which to help the client better understand his or her states of mind. The initial task of MBT is to help the client regulate emotion, because without affective control little can be done to make lasting internal personality changes. Thus, MBT includes a focus on validating the clients' affective states, and only secondarily challenges their perspective or offers interpretations (Gunderson et al. 2007).

Bateman and Fonagy (2010) assert that the primary aim of any intervention must be to assist the client with mentalization. Any intervention that assists in meeting this goal may be used in MBT. In fact, the authors (Bateman and Fonagy 2010) state that they do not ask practitioners to learn a new model of therapy, but that they modify their current practice by focusing on mentalizing rather than behaviors, cognitions, or insight.

Evidence for MBT

Preliminary evidence for Mentalization Based Treatment for individuals with BPD has been building. Bateman and Fonagy (1999) studied a MBT informed partial hospitalization program in contrast to a control group who received treatment as usual. They found that the MBT group showed significant decreases on all measures, including an improvement in depressive symptoms, decrease in suicidal and self-mutilatory acts, reduced inpatient days and better social and interpersonal functioning. These results began at 6 months and continued until the end of treatment at 18 months. The treatment as usual group showed limited change, or deteriorated during the same period. Bateman and Fonagy (2001) followed this same group of clients after 18 months of partial hospitalization or treatment as usual (TAU). They again found that the MBT clients improved significantly more than the TAU group on every measure. In the 8 year follow up, the authors found that only 13 % of the mentalization based group met diagnostic

criteria for BPD, compared with 87 % of the TAU group. The largest gains occurred in the areas of impulsivity and interpersonal functioning. Suicide attempts were 10× more likely in the TAU group (Bateman and Fonagy 2008). While these results are compelling, one limitation of this group of studies is that they are comparing clients who had ongoing, long-term partial hospitalization with those who were treated through standard psychiatric care, which included no psychotherapy. Thus, it is difficult to know if it is the intensity and structure of the intervention, or MBT that is the driving the positive outcomes.

Taken as a whole, the evidence on treatments for BPD seems to support the fact that a number of different treatment methods may be successful with this particular disorder. Zanarini (2009) who reviewed the literature on evidence based treatment for BPD concludes, "the evidence is not particularly strong that one treatment is better than another." They add, the "take home message may be that any reasonable treatment, provided by reasonable people, in a reasonable manner may be beneficial to these patients" (p. 376).

The lack of a clearly superior treatment may indicate that, in addition to the common factor of the therapeutic relationship, each of these treatments share important ingredients and interventions that lead to therapeutic progress. The provision of structure, the increase in awareness of states of mind, the ability to think dialectically, and the use of validation are important aspects that each of the above treatments value, and it may be that these "common elements" are responsible for the improvement seen in clients regardless of the treatment model used.

In addition, it is important to understand the differences between models for the treatment of BPD. Studies have indicated that different models of treatment have been found to be more effective for particular outcomes such as reducing suicidality (Linehan et al. 2006), reducing aggression (Clarkin et al. 2007), and improving attachment security (Levy et al. 2006b). Social workers would benefit from working toward a deeper understanding of the commonalities and differences between various models, which could ultimately allow for the thoughtful choice of the most effective interventions to use with each individual client, regardless of the manualized treatment from which it comes. Unfortunately, to date, there has been no exploration of which of the many interventions in BPD models are most effective with which clients.

While authors have argued against theoretical eclecticism, there seems to be some growing acceptance of technical eclecticism. Barth et al. (2012) have argued for the need for social workers to focus on the integration of evidence-supported elements within a practice framework that includes social work values and client preferences, over relying on manualized evidence supported treatments as a way to maximize positive outcomes. With respect to DBT, Chapman et al. (2011) recommend that therapists

“generally avoid attempts at the integration of alternative *theoretical frameworks* [italics added] into DBT” (p. 178) citing the importance of using a single theory in developing a coherent case conceptualizations, guiding treatment planning, and assisting clients in making sense of their symptoms and behavior. And yet, the same authors acknowledge that DBT itself is an “eclectic” approach, drawing from cognitive-behavioral, insight oriented, and Zen and humanistic traditions, and concede “eclecticism and flexibility in terms of *technique* [italics added] can be effective in DBT” (p. 178). Thus, there is some suggestion that a technical eclecticism, rather than theoretical eclecticism, may be useful in addressing the multiple, complex problems of individuals with BPD. While there is a small body of literature on integration of practice models and interventions in the treatment of BPD (Goldstein 1999; Heller and Northcut 1996; Westen 1991) there has been no exploration to date of the integration of MBT, TFP and DBT models.

Common Elements and Differences Between DBT, MBT and TFP

Promoting Dialectical Thinking and Alternative Perspectives

One key belief of DBT’s dialecticism is that reality involves a set of opposing forces that continually interact and change. DBT asserts that there is no one particular truth; there are always opposing perspectives to be considered in understanding any phenomenon. In fact, Linehan (1993) contends that BPD can be understood as a failure to integrate opposing views. She argues that a key dialectical failure often occurs when the client or therapist get stuck in the need to be “right.” MBT similarly has noted the difficulty of the BPD client in taking perspectives outside of herself, a hallmark sign of a failure of mentalization (Bateman and Fonagy 2006). TFP (Clarkin et al. 2006) also sees individuals with BPD as having a primary difficulty with integrating opposing views. The authors conceptualize this deficit as a difficulty with integrating disparate internal representations of themselves and others. The defensive use of “splitting,” or keeping hating and loving aspects of self and other as separate, are seen as a central aspect of borderline pathology. The use of splitting as a defense not only leaves individuals with difficulty integrating opposing views, but it also interferes with their capacity for reality testing, ability to modulate affect, and ability to develop healthy relationships. While there are subtle differences in how each model understands the difficulty that individuals with BPD have with integrating perspectives and mental states, all models suggest the use of interventions to

facilitate integration through promoting dialectical thinking or exploring alternative perspectives.

Use of Validation

These three models have significant overlap in their conceptualization of difficulty with integrating polarized states of mind as major deficit of BPD, however, they also have very different ways of approaching this deficit. Linehan (1993) sees validation as central to reducing dialectical thinking. The acknowledgement of polarity requires the therapist to recognize the value in what clients share about their experiences, even when those experiences are destructive, or clearly demonstrative of some level of distortion. One must find the constructive in the destructive, and the truth within the client’s reality. There is a constant awareness of the balance between opposing perspectives; what seems like distorted thinking may be indicative of a very valid expression of intense emotional pain. The goal is not to choose which to address in therapy (distortion or valid expression), rather to recognize both as real and important to understanding what is happening for that client in that moment.

This focus on the importance of validation is also evident in MBT. Bateman and Fonagy (2010) emphasize the importance of acceptance in their therapeutic technique. They believe that until the client’s feelings are validated, the therapist will have little success exploring their distortions. However, according to Bateman and Fonagy (2006), MBT does focus more on exploration than simply direct validation. MBT recommends first validating the client’s experience, but then exploring what has led to his or her particular interpretation of events. The clinician’s task is to accept the client’s experience without judgment, and then to quickly focus on understanding the factors leading to the experience, thereby promoting mentalizing.

In marked contrast to both DBT and MBT, there is little or no mention of validation in TFP, as proponents feel validation can interfere with helping the client to integrate “good” and “bad” aspects of self and other by keeping all of their negative experiences at bay. Yoemans et al. (2002) believe that if the worker is too validating, the client is unable to bring their anger and hostility into the room to be worked through in the relationship with the therapist.

Mindfulness and Mentalization

Bateman and Fonagy (2004) and Linehan (1993) both advocate increasing the client’s awareness as a central aspect of treatment. MBT calls this “reflective function” or “mentalization,” while Linehan uses the term “mindfulness.” For Linehan, mindfulness is a quality of acute awareness that is brought to current experience. It is a

broader term than mentalization, but includes attending to events, emotions and other behavioral responses with a non-judgmental stance. The central idea of mindfulness is that thoughts are just thoughts, and not “you” or “reality.” Thus, the therapist works to help the client to observe and describe his or her feelings and behaviors as *one aspect* of their reality. It is believed that one must be able to observe and reflect on emotional experiences before one can make effective choices about how to respond to those experiences. In DBT, mindfulness skills are the core skills of the treatment. Similarly, the ability to mentalize is the core skill of MBT. Mentalization is defined as “the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes” (Bateman and Fonagy 2010, p. 11) and thus has a more relational focus than mindfulness (although other aspects of DBT address interpersonal effectiveness). The goal of mentalization is to free the patient from being stuck in one perspective, to generate alternate perspectives and to experience and recognize an array of mental states. Thus, mentalization and mindfulness share many central goals such as observing and describing subjective states and helping clients learn “not to take her emotions and thoughts literally” (Linehan 1993, p. 145), or in MBT parlance, to use mentalization rather than “psychic equivalence.” However, mentalization and mindfulness do have differences. Bateman and Fonagy (2006) explain, “mentalization is essentially relational and takes in experience of the other as well as experience of one’s self and this helps distinguish these overlapping concepts.” (p. 162).

Integration of DBT, MBT, and TFP Interventions

Given that there are a number of commonalities between major parts of the DBT, MBT and TFP models, it becomes difficult to argue that these models can only be used as manualized models in their entirety, whose interventions cannot be utilized separately from the model as a whole. Rather than considering whether to use MBT, DBT or TFP with a particular client, perhaps the question that is more useful to social workers, is to consider which key *interventions* should be used with which client, and when. For example, Clarkin et al. (2007) demonstrated that while both DBT and TFP were effective for depression, anxiety, global functioning, social adjustment and suicidality across 1 year of treatment, when the treatments were compared for anger, impulsivity, irritability and verbal and direct assault, TFP was associated with the most improvement. This may be suggestive that more confrontational interventions allowing for more negative affect in the treatment relationship allow clients to work on their anger more directly. However, research to date has not attempted to

isolate which of the practice elements in these treatments are responsible for which positive outcomes.

In addition, Levy et al. (2006b) found when comparing DBT, TFP and modified psychodynamic supportive therapy that only TFP showed a significant increase in the number of clients classified as securely attached. They also found significant changes in reflective function for clients treated with TFP, but not with the other treatments. Thus, it may be that if the clinician is seeking to change entrenched relationship patterns, changes beyond symptom reduction, he or she may want to consider using some interventions drawn from TFP. The continuous focus on relationship through the transference may be useful in addressing these more characterological relationship issues. As MBT understands BPD though a failure of mentalization that occurs as a result of disordered attachment it may be that focusing on promoting mentalization would also be an intervention of choice to increase attachment security. DBT may also be particularly effective for certain symptoms. Linehan argues that DBT targets high-risk suicidal behavior in a more effective way than many other treatment models, and in fact, DBT has been found to be superior in reducing suicidality when compared to community treatment (Linehan et al. 2006). However, Clarkin et al. (2007) found no difference between TFP and DBT in reducing suicidality.

Clearly there is a need for additional research to explore the differences between these models in terms of specific outcomes and to begin to identify which interventions within models may be responsible for differential client changes. We must also remember that evidence-based practice includes not only appraisal of research evidence, but the integration this evidence with client preferences and circumstances, ethical considerations, availability of resources, and one’s own clinical expertise in making treatment decisions (Thyer and Pignotti 2011). The case example that follows demonstrates work with a client in which the author (S.B.) uses a variety of interventions drawn from the models described to meet the needs of the client. No manualized treatment was used, but instead, interventions were chosen based on the worker’s appraisal of the evidence, clinical expertise, and in response to a continuous assessment of client need, moment to moment, throughout the session. While no one BPD model was used exclusively, each model was useful to the social worker in guiding the treatment.

Case Example

Donna is a 27 year old Caucasian, Italian-American, Catholic woman who lives at home with her mother. Donna sought treatment for symptoms of depression. She said that she experienced intermittent periods of crying and feeling that her life was meaningless. She admitted to daily suicidal ideation, but denied a plan or any previous suicide

attempts. She also described periods of intense anger, when she would bully her boyfriend, mother or friends to the point where her relationships were often on the verge of ending. In addition, she experienced intense separation anxiety, and would become particularly enraged or depressed when she experienced others as abandoning her. Donna clearly manifested difficulties with dialectical thinking, a failure of mentalization, problems with attachment security, and lack of integration of self and other representations, and each of these ways of conceptualizing Donna were helpful to me in our work together.

One day, Donna came into her session furious that her sister was angry with her for missing her 21st birthday party. Donna explained, “why is a birthday so important? It is just a day of the year. And why should a particular number matter? 21 doesn’t mean anything more than 22. It is ridiculous. Also, I would hardly spend time with her at that big 60’s era party she was throwing. I did something much more meaningful and invited her to have lunch with me the next day. I don’t see why she should be upset with me!”

My first impulse was to empathize with the sister. I thought, “how could Donna miss her sister’s party? How narcissistic of her.” I was aware of the defenses Donna was employing to minimize the extent of the hurt she had inflicted. TFP would have recommended clarification leading to confrontation of the client’s aggressive behavior, but my experience with Donna, and DBT and MBT models told me I needed to focus on validation first. Instead of confronting her distortions or behavior, I commented on her feeling upset that her sister didn’t understand her and validated her feelings of being misunderstood.

Following an MBT model, I used validation followed quickly by exploration. I asked Donna more about her reasons for missing the party. At first she insisted she was just tired and that there were no reasons. As she was having difficulty mentalizing, and my more cognitive “exploration” was having little effect, I decided to coach her in the use of the more experiential mindfulness skills she had learned in a DBT group she was attending as an adjunct to our work together. After reminding her to “observe, participate and describe” her feelings and to be in the moment, Donna was able to begin to attend to her emotions and internal states in the session.

As is advocated from an MBT perspective, I continued to focus on Donna’s mental states leading up to her missing the party. After further exploration, Donna spoke about her fear of family members, who would be at the party, looking down on her because she is not more successful. She spoke about the success of the many cousins she would have to see, and how they would all pressure her about going back to school, or getting a job. She spoke about the long-standing feelings of never measuring up to expectations of

a demanding father who separated the world into “losers” and “winners.”

As she spoke, I began to empathize with her more, and I validated the fact that she would feel anxious about attending the party given the family history and dynamics. My being able to find something to validate in Donna’s story was important for my ability to “accept” her, and also seemed to immediately calm her down. When she was less emotionally dysregulated, I asked Donna to think about times when her own father had failed to be present for important events in her life. This was partially an attempt to promote mentalizing—by helping Donna put herself in the position of feeling abandoned, I hoped it would help her to begin to understand her sister’s perspective more clearly. In addition, I was trying to help to increase her awareness of her identification with the split off “abandoning object” from her past and how this is played out in her present relationships, a TFP intervention. (Later, in another session, I would go back to this example when similar issues came up between the two of us in our relationship and would help Donna see the way she replayed these aspects of self and other with me—again, in keeping with TFP).

As she was able to put herself in her sister’s shoes, she was able to begin to think more dialectically herself. I was then able to talk about her sister’s hurt feelings, and how they may have stemmed from a true caring for Donna, and a genuine wish to have her present at the party (helping her with mentalizing and alternative perspectives). I found Donna was able to respond to a confrontation about her sister’s perspective, having first had her perspective understood. Feeling understood, Donna went on to think about ways she might be able to manage her anxiety about family pressure differently in the future (using DBT change skills, which I don’t think she could have used earlier in the session until she felt understood).

The case study is not meant to illustrate “the” way to integrate multiple models of BPD but to demonstrate “a” way that was useful with one particular client. It demonstrates an example of the ways in which many social workers draw from multiple models to meet the needs of their clients. While sharing these examples of “real world” practice are an important step toward creating a dialogue on more integrated ways of practicing, we also need to continue to more systematically identify the practice elements that are most effective for clients, and under which conditions.

Conclusion

While there are significant differences between DBT, MBT and TFP there is also much overlap in their understanding of BPD and in crucial treatment methods utilized by each model. By elucidating these similarities and differences,

we hope to begin a conversation about the possibilities of integrating techniques from each of these models, which have been kept quite separate in the literature. All of the models have a similar biopsychosocial understanding of the etiology of BPD, a focus on synthesizing opposing affects and mental states, and a focus on increasing the client's capacity for mindfulness or reflection. It may be that these similar factors are responsible for the therapeutic change seen in outcome studies of the various models, and may explain why the research so frequently finds that DBT, TFP and MBT have all been found to be effective in the treatment of BPD (Zanarini 2009; Clarkin et al. 2007).

The literature on the treatment of BPD seems to have found itself in the same non-dialectical trap that MBT, TFP and DBT models caution against. Treatment methods are seen in opposing, competing “or” polarities and there is little discussion of the “and”—the integration of models. Barth et al. (2012) have argued that the implementation of evidence informed practice is at a crossroads in social work. Social work practitioners have experienced challenges with the application of manualized evidence-supported treatments as they require extensive and expensive training and supervision, require collaboration with other practitioners which may not be available to clinical social workers in smaller agencies or independent practice. Additionally, evidence supported treatments are often longer-term treatments, and may not fit the individual client's complex needs when used in isolation. Social workers need to engage in ongoing discussion about the commonalities and differences between models with the goal of identifying the best practices for individual clients. With our history and ethical guidelines of putting client needs first, social workers are poised to be on the forefront of this next phase of practice development. Only by focusing on the integration of evidenced based treatments within the framework of our social work values and client needs, will we be able to maximize our treatment effectiveness with vulnerable populations.

Conflict of interest The authors declare that they have no conflicts of interest.

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